SETTLING FOR SECOND BEST

WHEN SHOULD DOCTORS AGREE TO PARENTAL DEMANDS FOR SUBOPTIMAL TREATMENT?

TARA NAIR[1] **25175084** *Supervisors*: A/Prof Dominic Wilkinson[2], Prof Julian Savulescu[2], Dr Ryan Tonkens[3]

THE PROBLEM

Doctors sometimes encounter parents who object to prescribed treatment for their children and **request suboptimal conventional alternatives**.

Our case: Parents of a premature neonate with Respiratory Distress Syndrome decline standard porcine-derived **Surfactant Replacement Therapy** and request an alternative preparation

These requested treatments may be more **harmful** or more **expensive** than the recommended treatment.

Existing literature examines refusal of treatment, particularly in life or death situations; however, the question of **when a doctor ought to allow or override a parental request for an alternative** has been left unanswered**.**

AIM

- To test the public's intuitions regarding **thresholds for acceptable harm and expense** and assess the effect of the parents' **reason**
- To appraise **existing theoretical frameworks** for parental freedom and compare them with our data

METHODS

- **Online survey** with a sample of the North American public
- **Statistical analysis** conducted on IBM SPSS Statistics
- **Ethical analysis** of existing frameworks
- Descriptive and normative outcomes were **compared**

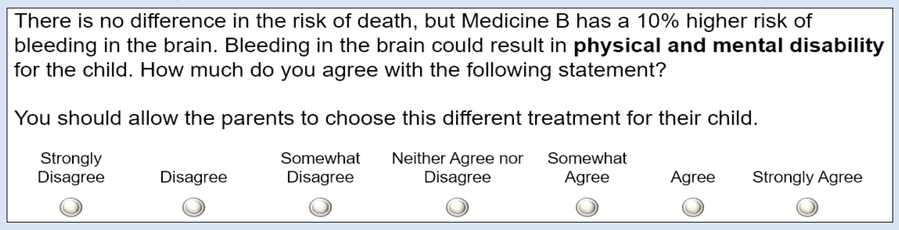


Figure 1. Sample survey question

RESULTS

242 survey respondents, 178 valid responses (73.6%)

Religiously motivated requests were significantly **more likely** to be allowed ($p<0.001$)

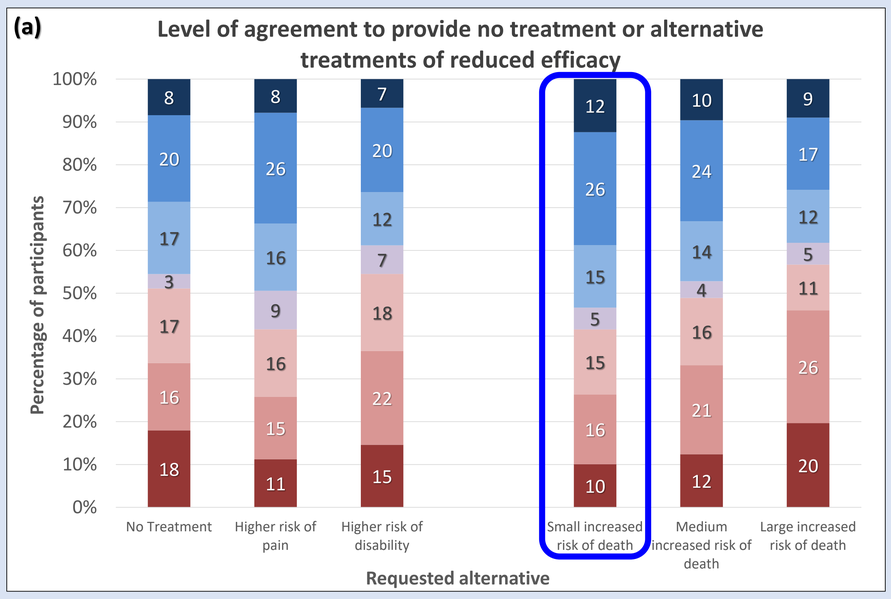
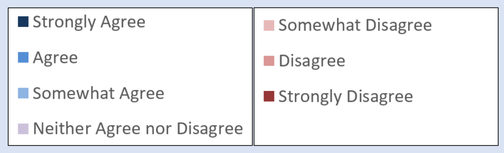


Figure 2. Level of agreement to provide alternative treatments of (a) reduced efficacy (b) increased expense

Thresholds

More than 50% of participants agreed to requests for alternative treatments that imposed:

- **<5% increased risk of serious harm**
- **<$500 additional expenditure**



WHAT SHOULD WE DO?

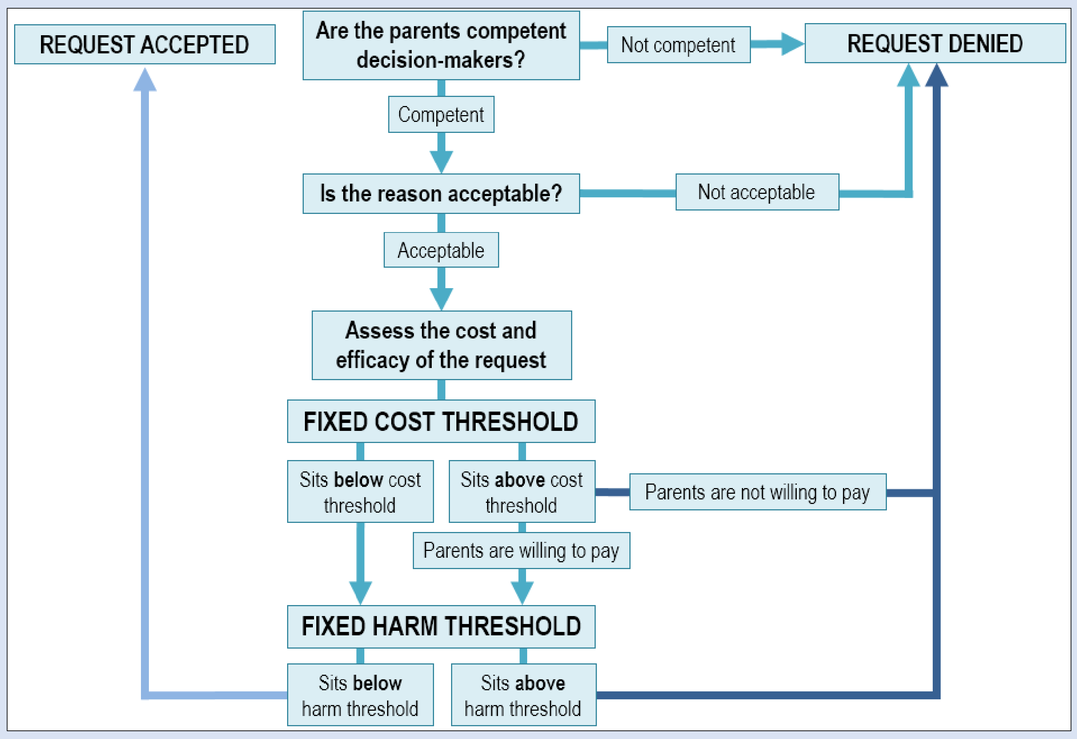


Figure 3. Three-staged reason-based fixed thresholds model

In our framework, the doctor should:

1. Assess the **competency** of the **decision-maker**
2. Assess the **appropriateness** of their **reason**
3. Measure the request against the **fixed cost and harm thresholds**

Reasons are not weighted but simply considered acceptable or not.

CONCLUSIONS

- The public was significantly more likely to ***refuse*** requests for treatment that were much **less effective**, or much **more costly** than the standard treatment.
- The public was more inclined to ***allow*** these requests if provided with a **religious reason** compared to a non-religious reason.
- Further research is needed to test our model and work towards ethically sound thresholds

1. Faculty of Medicine, Nursing and Health Sciences, *Monash University*, 2. Uehiro Centre for Practical Ethics, *University of Oxford*, 3. Centre for Human Bioethics, *Monash University*